Patient Information

Salutation	First Name	Last Name	M.I.
Date of Birth	Social Security Number		Gender
E-mail	Mobile ( )	Home ( )	
Home Address		Apt	
City	State	Zip	
Employer Name			
Occupation	Employer Phone ( )		
Referring Doctor	Family Dentist if different		
Family Physician	Family Physician Phone ( )		
Insurance Information (if applicable)			
Name of Policy Holder	Policy Holder Date of Birth		
Relationship	Policy Holder's Employer		
Dental Insurance Company	Insurance Phone ( )		
Member/Subscriber ID	Policy Holder SSN	Group#	

Medical History

	Yes	No	Don't Know
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain-			
2. Has there been any change in your general health within the past year? If yes, explain-			
Change:			
3. Are you under the care of a physician for a current problem? If yes, explain below-			
Current Problem:			
4. Have you been hospitalized within the past 5 years? Please specify below-			
Hospitalization:			
5. Are you taking any medication (prescribed, OTC, herbal) or drugs? Please list below-			
Medications:			
6. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications/other? Please list below-			
Allergies:			
8. Is there any condition concerning your health that the doctor should be told?			
Concern:			
9. Do you wish to speak to the doctor privately about anything?			
10. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
11. Have you ever required a blood transfusion?			
12. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
13. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
14. Are you required to take antibiotics prior to dental treatment?			

Please continue

Do you have or have you had any of the following?

☐	High blood pressure	☐	Sinus trouble
☐	Heart murmur or prolapsed valve	☐	Thyroid problems
☐	Joint prosthesis (hip, knee, etc.)	☐	Diabetes
☐	Rheumatic fever or rheumatic heart disease	☐	Stomach ulcers, colitis
☐	Congenital heart disease	☐	Hepatitis, jaundice, liver disease
☐	Cardiovascular disease: heart attack, stroke or bypass	☐	Psychiatric treatment
☐	Prosthetic heart valve	☐	Fainting spells or seizures
☐	Blood disorder (e.g. anemia)	☐	Epilepsy
☐	Venereal disease	☐	Cancer
☐	Asthma	☐	Temporomandibular joint problems (TMJ)
☐	Allergy to latex	☐	Low blood sugar
☐	Low blood pressure	☐	Dialysis
☐	Chest pain, angina	☐	Irregular heartbeat
☐	Swollen ankles, arthritis or joint disease	☐	Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with the immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	X-Ray treatment or chemotherapy	☐	History of drug abuse
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	None of the above

	Yes	No	Don't Know
15. Have you ever taken the "fen-phen" diet?			
16. Do you have any disease, condition or problem not listed above? Please specify below-			
Other:			

Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Injury:

This visit is related to an accident	YES / NO	Work related:	YES / NO
Date of injury:			
Insurance company handling the claim:			
Claim Number:			

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the office of any changes in my medical status.

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age). Date